*Today's* **Solution** *for* **Tomorrow's** Health



**Testimony of**

***PARTNERSHIP FOR PREVENTION***

***on***

**Medicare Preventive Benefits and Quality Standards**

**b e f o r e t h e**

**Subcommittee on Health and the Environment**
**Committee on Commerce**
**United States House of Representatives**

**April 11, 1997**

**Presented By**

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## Summary

*Partnership for* Prevention is a national nonprofit educational and policy research organization whose diverse members share an interest in finding effective ways to make prevention an integral part of national health policy and practice. *Partnership* has three key recommendations for the Medicare program

1. **Medicare should cover those preventive services recommended by the U.S. Preventive Services Task Force, including--and perhaps especially--the counseling services identified. Further, Congress should authorize the Secretary of Health and Human Services to modify Medicare's coverage of preventive services in order to respond to advances in science and new evidence of effectiveness.**

Perhaps the most important practical implication of this perspective is that rather than cover services whose benefits are still *not* proven, such as PSA screening for prostate cancer, Medicare should cover preventive counseling services, which we know are effective and can have a substantial impact on health and quality of life. Such services would include counseling on matters such as smoking cessation, diet and exercise, injury prevention and dental health.

2. **Congress and the Administration should reduce barriers to the use of preventive services.**

Many studies have found that participants in cost-sharing insurance arrangements are the least likely to use preventive care of any type. *Partnership* strongly encourages the Subcommittee to remove all financial barriers, including copays, deductibles and balance billing, to use of Medicare's preventive services. There has been much attention to the matter of mammography for women ages 40-49--but the real attention should go to the fact that among women 50 and over, for whom there is no doubt that mammography can save lives, only about half receive the service.

3. **Finally, Partnership recommends that Medicare utilize those tools proven to he effective to empower beneficiaries to make informed health care decisions.**

A number of self-management support and information tools--nurse-staffed telephone services, self-care publications, group and individual education programs--appear to be effective in improving health and reducing the costs of care. This area deserves a closer look by Congress and HCFA, and we encourage additional research, perhaps through demonstration projects, to assess its utility for the Medicare program.

Mr. Chairman and members of the Subcommittee, I am Robert Harmon, National Medical Director for United HealthCare Corporation's OPTUM Division & Medical Services Group and a member of ***Partnership for Prevention's*** Board of Directors, on whose behalf I appear today. ***Partnership for Prevention*** is a national nonprofit educational and policy research organization whose diverse members share an interest in finding effective ways in which prevention can be made an integral part of national health policy and practice. (Appendix A lists the members of ***Partnership for Prevention.)*** The Subcommittee should also know that my testimony has been endorsed by the American College of Preventive Medicine, where I am also a fellow.

I am pleased to have this opportunity to testify before you today in support of improving Medicare's package of preventive benefits. Although Medicare's lack of coverage for preventive services has been debated in years past, it has been quite some time since this issue has received such scrutiny by the Congress. ***Partnership*** is encouraged by the opportunity that this reinvigorated discussion represents and commends Chairman Bilirakis for his leadership in introducing the Medicare Preventive Benefit Improvement Act (H.R. 15) and his colleagues on the Commerce Committee for cosponsoring it.

My testimony today is guided by three general recommendations, advanced ***by Partnership for Prevention,*** that address Medicare's coverage of preventive services:

- ***Medicare should cover those preventive services recommended by the U.S. preventive Services Task Force.***

- ***Congress and the Administration should reduce barriers to the use of all preventive services.***

- ***Medicare should utilize those tools proven effective to empower Medicare beneficiaries to make informed decisions about their own health, to adopt healthy behaviors, and to make appropnate use of medical care***

### *Partnership for Prevention*

*Partnership for* ***Prevention*** was founded in 1990 to provide private-sector leadership in achieving the Healthy People 2000 national health objectives. The mission of the organization is to increase the priority for prevention among policy-makers, federal and state agencies, corporations and other nonprofit organizations. In making our case, we adhere to the highest standards of scientific evidence. While there are many organizations and associations active in the field of health promotion and disease prevention, ***Partnership for Prevention*** coordinates and focuses the efforts of existing groups in order to achieve significant changes in national health policies with an emphasis on prevention. Members of *Partnership* represent some of the leading organizations in business and industry, professional and trade associations, universities and academic health centers, civic organizations, nonprofit disease groups and state health departments.

*Partnership* also endeavors to be a resource for Members of Congress and their staff by providing educational resources, such as our "Prevention Primer," and our recent Medicare forum. This forum, at which you, Mr. Chairman, Congressman Cardin, and Chairman Thomas spoke, provided more than 200 attendees with information about the importance of prevention for seniors. Currently, we are working to assist in the development of a new Congressional coalition, comprising Members of Congress with an interest in prevention issues, in order to supplement our efforts to provide both legislators and staff with educational, scientific information about prevention.

### The Prevention Context for H.R. 15

H.R. 15 represents a significant advance toward the goal of providing seniors with access to needed preventive services. Clinical preventive services, such as mammography, colorectal cancer

screening tests, and immunizations, are a key part of a broad strategy to prevent disease and promote healthy lifestyles for older Americans. However, clinical prevention is not the ***only*** element of a comprehensive approach to health promotion and disease prevention. Many of prevention's most promising opportunities are often overlooked because prevention is so narrowly defined in the eye of the public. Prevention is a much broader concept than a regular checkup or regular screening. A safe water supply, regular exercise, and seat-belt laws are all part of prevention. So are strategies to reduce violence in our communities and to fluoridate drinking water.

*Partnership for Prevention* espouses three components of a comprehensive prevention program: (1) clinical preventive services, such as immunizations, screening tests, and counseling interventions; (2) community-based preventive ***services*** and public health activities, such as health education, surveillance of health status and monitoring of air, water and food; and (3) prevention-oriented social and economic policies, such as legal and regulatory actions that reduce exposure to harmful substances and education and financial incentives that reinforce healthy behaviors. *Partnership for Prevention* advocates integrating prevention, in all its varied forms, into our health care and public health system.

***Partnership also*** strongly supports strategies that foster such integration, including programs and tools that encourage healthful behaviors and the self-management of chronic and acute conditions. For example, evidence is mounting that consumers who have access to self-management tools, such as self-care books and nurse help lines, tend to use medical services less frequently and make informed decisions about their lifestyles and treatment options. As an added bonus, some studies show that such "self-care" strategies may save money--something in which I know the members of this Subcommittee are interested!

## Preventive Services for Older Americans

While the value of prevention for younger persons is now commonly accepted, this has not always been the case with older individuals. The fact is, scientific evidence shows that adults over the age of 65 have much to gain from health promotion and disease prevention. At age 65, the average American has a life expectancy of 17 years. However, for the average person, not all of these years will be active and independent ones. For older Americans, improving the *quality* of life, not just the *length* of life, is a key goal of prevention. Currently, only about 12 of ***17*** years of additional life expected for **people** age 65 can be anticipated to be "healthy''--the other five being significantly compromised by some chronic condition.' While many believe that health problems in old age are inevitable, in actuality many of these conditions are either preventable or can be controlled--increasing the number of years of healthy life remaining and the ability of older Americans to live independently.

## Improving Medicare's Coverage of Clinical Preventive Services

Despite agreement on the benefits of prevention for older Americans, Medicare lacks basic coverage for preventive services. ***Partnership*** has identified a number of areas where Medicare could be improved to better reflect scientific evidence.

**Recommendation 1:** ***Medicare should cover those preventive services recommended by the U.S. Preventive Services Task Force. Further, Congress should authorize the Secretary of Health and Human Services to modify Medicare's coverage of preventive services in order to respond to advances in science and new evidence of effectiveness. Authorizing legislation should include criteria for assessing the appropriateness of such services, such as proof of efficacy, impact on quality of life, and relative value of return on investment.***

In 1984, the U.S. Public Health Service convened a panel of prominent primary and preventive health care specialists to develop guidelines for preventive services. From this panel, the U.S. Preventive Services Task Force's *Guide to Clinical Preventive* ***Services*** was born. While many other respected professional and research organizations have issued their own recommendations, the landmark *Guide* is widely regarded as the "gold standard" reference on the effectiveness of clinical preventive services--including screening tests, immunizations, and counseling interventions. In December of 1995, a new Task Force released an updated and expanded second edition of the ***Guide*** which includes findings ***on*** 200 preventive interventions for ***more*** than 70 diseases and conditions. The Task Force employed a rigorous methodology to review the evidence for and against hundreds of preventive services, assessing more than 6,000 studies. The Task Force recommended specific screening tests, immunizations, or counseling interventions only when strong evidence demonstrated the effectiveness of a given preventive service. And because the Task Force developed age specific recommendations, its work is especially useful when considering the effectiveness of specific preventive services for a defined age group, such as the Medicare population. Listed in Appendix B are the recommended interventions for the asymptomatic population aged 65 and older.

H.R. 15 moves the Medicare program closer to the recommendations of the Task Force by covering services including sigmoidoscopy and fecal-occult blood tests for screening colorectal cancer. H.R. 15 also covers clinical breast exams. And although not directly addressed by the ***Guide,*** *Partnership* ***also*** believes coverage for diabetes self-management screening is long overdue and based in strong science and economics. Enacting this legislation would be a significant step forward in our efforts to enhance the health and quality of life for our nation's seniors.

*Partnership* believes that, given the need to spend public dollars wisely, Congress should first

cover those services that the Task Force has found to be effective. In the case of those services that the Task Force has found insufficient evidence to recommend for or against, *Partnership* does not take a position on their inclusion in the bill, but we do support additional research to determine the effectiveness of these interventions. ***Partnership*** does not recommend that the Medicare program cover services that the Task Force has specifically recommended against.

The most important practical implication of this perspective is that rather than cover services whose benefits are still not proven, such as PSA screening for prostate cancer, Medicare should cover preventives services we know can improve health.

Perhaps the most overlooked preventive service is counseling patients about personal health practices, It is also the strategy that holds the most promise for preventing disease before it develops and improving the overall health status of Americans. Such services would include counseling on matters such as smoking cessation, diet and exercise, injury prevention and dental health.

While death certificates tell us that heart disease, cancer and stroke are the leading causes of death, in fact, the *actual* leading causes of death among U.S. residents are tobacco, diet and inactivity patterns, alcohol, microbial agents, toxic agents, firearms, sexual behavior, motor vehicles and illicit use of drugs. Based on these estimates, half of all premature death is potentially preventable.* For example, the largest contributor to death among U.S. residents is smoking..' Medicare will spend an estimated $800 billion over the next 20 years caring for people with smoking-related illnesses.' Similarly, older adults can obtain significant health benefits with a moderate amount of physical activity. Although proven to reduce the risk for coronary heart disease, hypertension, obesity, and diabetes, by age 75, about one in three men and one in two women engage in no physical activity.[5]

For a number of these important health-related behaviors, including smoking and physical activity,

there is good evidence that clinicians can change patient behavior through simple counseling interventions. Unfortunately, Medicare does not currently reimburse physicians for preventive medicine counseling services.

The U.S. Preventive Task Force's strict reliance on only the most current and scientifically defensible information can help Congress neutralize the political debates over specific services. For example, the media has highlighted the disagreements between medical specialty groups over coverage for the barium enema test for colorectal cancer. That there are differing opinions about the effectiveness of this service should not be surprising. For some screening tests, including barium enema, conclusive proof of effectiveness is simply not yet available--provoking healthy discussions about the effectiveness of services where the science is unclear. Focusing on these areas of disagreement, however, misses the more important point. For many preventive services, clear evidence of effectiveness does exist. Yet, Medicare often does not even cover those services we *know* are effective. Congress should not allow the debates over screening tests we're not sure about get in the way of covering preventive services we know work.

More generally, I would also strongly encourage the Subcommittee to ensure that the useful information provided by the U.S. Preventive Services Task Force *Guide* is available and updated into the future. The Task Force, currently housed at the Agency for Health Care Policy and Research (AHCPR), provides an invaluable reference for clinicians and policymakers alike. ***Partnership*** believes that Congress should support efforts to ensure that the most updated scientific information about the effectiveness of preventive services remains available.

To take this one step further, Partnership recommends that Congress authorize the Secretary of Health and Human Services to modify Medicare's coverage of preventive services in order to respond

to advances in science and new evidence of effectiveness (or ineffectiveness). Such a provision should require the Secretary to issue criteria for assessing the appropriateness of such services, such as proof of efficacy, impact on quality of life, and relative value of return on investment. This would enable the Secretary to act quickly to cover preventive services that are newly proven to be effective. The fact is, scientific evidence continues to emerge. Recommendations not issued today may be validated tomorrow and vice versa. If our public programs are expected to keep pace with these changes, they must have the flexibility to do so.

***Recommendation 2: Congress and the Administration should reduce barriers to the use of all preventive services.***

Researchers have identified numerous barriers limiting access to preventive services. For example, the RAND Health Insurance Experiment found that participants in cost-sharing insurance arrangements were the least likely to use preventive care of any type,[6] and recent studies have demonstrated that co-payments are an obstacle to the effective mass screening of older women for breast cancer.'

H.R. 15 removes a number of these important financial barriers, by waiving deductibles for mammography and Pap tests and eliminating balance billing for colorectal cancer screening tests. ***Partnership*** strongly encourages the Subcommittee to not only retain these critical financial incentives, but to strengthen the bill even further by applying such utilization incentives to *all* of Medicare's preventive services and waiving not only deductibles and balance billing charges but also the 20% copayment. Prevention does not work unless it is utilized. Presumably, one of the key goals of this legislation is to increase seniors' utilization of preventive services. Without the cost-sharing waivers, significant barriers to utilization will remain.

Nonfinancial barriers to preventive services also exist, such as inadequate patient knowledge, physician inattention to prevention needs and opportunities, and the inadequate supply and distribution of primary care providers. Outreach programs such as HCFA's Health Status Improvement Consumer Information Program (HSICIP), which encourage greater use of preventive care benefits through a coordinated educational campaign, are excellent examples of targeted attempts to remove nonfinancial barriers that have *Partnership's* support.

Furthermore, *Partnership* believes a closer examination of the optimal unit of payment for preventive procedures is merited. For example, paying for a package of preventive services or activities, as opposed to reimbursing for individual procedures, may economize on cost and paperwork as well as provide the health care provider with an opportunity to integrate related services and educational materials. A potentially preferable approach to the current incremental procedure-specific reimbursement may be to provide for a package of preventive services in an explicit periodic preventive health visit. A number of Medicare demonstration projects implementing such an approach have reported encouraging results. In 1985, Congress authorized five national demonstration projects to test the cost effectiveness of preventive health measures in reducing the use and costs of health care services for Medicare beneficiaries. The San Diego demonstration reported that an intervention of education and counseling, coupled with annual exams, had a lasting effect on health behavior. At the same time, the study indicated that seniors enrolled in the demonstration did not significantly increase their use of physician or hospital services or incur increased costs associated with these services compared to seniors who were not enrolled in the demonstration. Other projects, including the John Hopkins and UCLA sites, reported similar results. Although the final analysis by an independent evaluator has not yet been submitted, these projects

offer some initial information about the potential of prevention to both improve health and decrease program costs.

A more narrow but related strategy is to provide beneficiaries, upon becoming eligible for Medicare, with a comprehensive "welcome to Medicare" visit. Such a visit would include a comprehensive risk assessment, mobilizing individuals to adopt healthful behaviors and take advantage of regular screening appointments. *Partnership for Prevention* is currently exploring this idea and encourages Congress to do the same.

Regardless of the payment or delivery mechanism adopted, however, health professionals should be encouraged to inform their patients about the importance of prevention. In the absence of a periodic health exam or initial wellness visit, clinicians must take every opportunity to deliver preventive services. While checkups may allow for more time for counseling and other preventive care, *every* patient visit provides an opportunity to practice prevention. This is especially important for Medicare beneficiaries who may be willing to accept a single quick intervention as part of another visit but not willing or able to make a special trip to the doctor for a more comprehensive package of services.

***Recommendation 3:*** ***Medicare should utilize those tools proven to be effective to empower beneficiaries to make informed decisions about their own health, to adopt healthy behaviors, and to make appropriate use of medical care.***

Studies show that a wide-range self-management support and information tools such as nurse-staffed telephone services, self-care publications, group and individual education programs, and traditional health promotion programs can improve health, increase patient satisfaction, and result in more appropriate use of health care services. These tools can also often save money,

There is a growing body of research that demonstrates the potential of self-care tools to reduce utilization of health care services. A recent study in Wisconsin found that individuals given self-care print materials as well as access to a nurse call line had 25% fewer outpatient visits.[8] Making these services available to Medicare beneficiaries offers the possibility of substantial cost savings and high quality health care. For example, in one study, Medicare managed care beneficiaries receiving a self-care manual experienced a 15% decrease in overall medical visits compared to a control group. The program produced a benefit/cost ratio that appears today to be approximately four dollars saved for every dollar invested.' This is an area that ***Partnership*** believes deserves a closer look by Congress and HCFA, and we encourage additional research, perhaps through demonstration projects, to reveal its utility for the Medicare program.

## Medicare Managed Care and Prevention

Finally, I would like to point out the opportunities that the growth of Medicare managed care has for prevention. Although currently less than 15% of Medicare beneficiaries are enrolled in managed care programs, this rate will likely grow dramatically over the next decade. The Congressional Budget Office estimates that, by the year 2007, 35% of Medicare beneficiaries will be receiving their care through managed care arrangements. This growth offers Medicare an important opportunity to promote the delivery of preventive services in an efficient manner. Most managed care plans currently offer Medicare beneficiaries preventive services in addition to their basic Medicare benefits. More than 86% of plans offer beneficiaries additional immunizations, 94% cover routine physicals, 79% pay for eye exams, 32% provide health education services, 97% cover ear exams and 39% cover preventive dental care.[10] In addition, managed care organizations offer the potential to implement

community-based approaches to prevention.

While Medicare's capitated payment system is an important enabling factor in this enhanced benefit system, it is not the *only* lever available to encourage the provision of preventive services in managed care. Performance and outcome measures are important tools that can prod providers in a new direction. For the first time, HCFA will require its managed care contractors to report HEDIS 3.0 measures, including rates for flu vaccine, mammography, diabetic retinal screening, beta-blockers in myocardial infarction, and advice to quit smoking. It will also require plans to report on a new outcome measure, the health of seniors. The first attempt to evaluate "outcomes" of the Medicare population, this measure will look at the health status of beneficiaries in managed care plans over a two-year period. *Partnership* ***for Prevention*** strongly supports the implementation of such performance measures because we believe that plans will seek to achieve results on which they are measured and for which they are accountable.

## Conclusion

H.R. 15 is important to our nation's prevention strategy because it recognizes the value of prevention for older Americans, aims to increase not just access to but utilization of preventive services, and moves Medicare's benefit package closer to the recommendations of the U.S. Preventive Services Task Force.

*Partnership* recognizes that in this current fiscal environment, moving legislation forward that has any price tag at all can be very difficult. But it is important to remember that prevention is an *investment*. As with medical treatment, the costs of preventive interventions vary tremendously. There are some preventive services we know save money, such as immunizations and self-care tools.

However, even when prevention does not save money for Medicare, it improves the quality of life and health of Medicare beneficiaries at a reasonable cost.

It is also important to recognize that prevention in the clinical setting alone is not the answer. Addressing the *true* causes of death in the United States will require a far more coordinated approach that includes not only clinicians but communities. We need to do a better job of integrating prevention, in all its varied forms, into our health care system. Improving the health status of seniors, indeed all Americans, demands that individuals assume more responsibility for their own health. Government must continue with its efforts to support research so that the most up-to-date, scientific information is available to help us all assume this responsibility.

There is no doubt that prevention will *be* increasingly important as the baby boom generation ages. Today there are 33 million Americans over the age of 65. In the next century we will see this number grow to more than 77 million. Treating problems as they occur is not enough. The need to maintain and enhance the health and quality of life for our nation's seniors and to get the most for our health care dollar demand that prevention be an integral part of an improved Medicare program.

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# Partnership for Prevention Members

Organizations

American Academy of Pediatric Dentistry
American Association of Health Plans
American Association of Dental Schools
American Cancer Society
American College of Preventive Medicine
American Dietetic Association
American Medical Association
American Nurses Association
American Physical Therapy Association
American Podiatric Medical Association
American Public Health Association
Association of Academic Health Centers
Association of Schools of Public Health
Association of State and Territorial Health Officials
Association of Teachers of Preventive Medicine
Association for Worksite Health Promotion
Blue Cross of Western Pennsylvania
Cecil G. Sheps Center for Health Services Research
Center for the Advancement of Health
Central States of Omaha
Columbia University, Center for Applied Public Health
Connaught Laboratories
Glaxo Wellcome
Health Decisions International
Health Insurance Association of America
Health Management Corporation
The Health Project
Henry Ford Health System
Institute for Advanced Studies in Immunology & Aging
International Health, Racquet & Sportsclub Association
JC Penney, Inc.
Johnson&Johnson
Merck & Co.
National Association of Community Health Centers
National Association of County and City Health Officials
National Association of Pediatric Nurse Associates and Practitioners
National Black Nurses Association
National Association of School Nurses
Pennsylvania Blue Shield
Pfizer, Inc.
Prudential Center for Health Care Research
Schering-Plough Corporation
Society of Behavioral Medicine
Time Life Medical
United HealthCare Corporation
VHA, Inc.
Wellness Councils of America
Wyeth-Lederle Vaccines and Pediatrics

States

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Nevada
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Pennsylvania
Rhode Island
S. Carolina
Tennessee
Texas
Utah
Washington
West Virginia

3/20/97

| U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS (FOR ASYMPTOMATIC INDIVIDUALS) | MEDICARE COVERAGE* | |
|---|---|---|
| **Interventions for the General Population- Age 65 and Older** | | |
| **SCREENING** | **YES** | **NO** |
| Blood Pressure | | ✔ |
| Height and Weight | | ✔ |
| Fecal occult blood test and/or sigmoidoscopy | | ✔ |
| Mammogram + clinical breast exam (women ≤ 69) | ✔ | |
| Pap test (women) | ✔ | |
| Vision screening | | ✔ |
| Assess for hearing impairment | | ✔ |
| Assess for problem drinking | | ✔ |
| **COUNSELING** | | |
| Substance Abuse | | |
| Tobacco cessation | | ✔ |
| Avoid alcohol/drug use while driving, swimming, boating etc. | | ✔ |
| Diet and Exercise | | |
| Limit fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables | | ✔ |
| Adequate calcium intake (women) | | ✔ |
| Regular physical activity | | ✔ |
| **Injury Prevention** | | |
| Lap/shoulder belts | | ✔ |
| Motorcycle and bicycle helmets | | ✔ |
| Fall prevention | | ✔ |
| Safe storage/removal of firearms | | ✔ |
| Smoke detector | | ✔ |
| Set hot water heater to <120-130 degrees Fahrenheit | | ✔ |
| CPR training for household members | | ✔ |
| Dental Health | | |
| Regular visits to dental care provider | | ✔ |
| Floss, brush with fluoride toothpaste daily | | ✔ |
| Sexual Behavior | | |
| STD prevention; avoid high-risk sexual behavior; use condoms | | ✔ |
| **IMMUNIZATIONS** | | |
| Pneumococcal vaccine | ✔ | |
| Influenza | ✔ | |
| Tetanus-diphtheria (Td) boosters | | ✔ |
| **DRUG THERAPY** | | |
| Discuss hormone replacement therapy (peri- and postmenopausal women) | | ✔ |

**Interventions for High-Risk Populations- Age 65 and Older**

| POPULATION | INTERVENTIONS | MEDICARE COVERAGE |
|---|---|---|
| Institutionalized persons | TB test; hepatitis A vaccine; amantadine/rimantadine | No |
| Chronic medical conditions: TB contacts; low income; immigrants; alcoholics | TB test | No |
| Persons over 75 years: or older than 70 years with a risk factor for falls | Fall prevention intervention | NO |
| Cardiovascular disease risk factors | Cholesterol screening | No |
| Family history of skin cancer; nevi; fair skin,, eyes, hair | Avoid excess/midday sun, use protective clothing | No |
| Native Americans/Alaska Natives | TB test; hepatitis A vaccine | No |
| Travelers to developing countries | Hepatitis A vaccine; hepatitis B vaccine | No/Yes** |
| Blood product recipients | HIV screen; hepatitis B vaccine | No/Yes** |
| High-risk sexual behavior | Hepatitis A; HIV screen; hepatitis B; screen for venereal disease | No/Yes** |
| Injection or street drug use | TB test,; hepatitis A; HIV screen; hepatitis B vaccine; screen for venereal disease; advice to reduce infection risk | No/Yes** |
| Health care/lab workers | TB test; hepatitis A vaccine: anatadine/rimantadine, hepatitis B vaccine | No/Yes** |
| Persons susceptible to varicella | Varicella vaccine | NO |

* Some Medicare managed care plans may cover additional preventive services.
** Medicare covers the hepatitis B vaccine for Medicare beneficiaries at high risk of contracting hepatitus B.

**ROBERT GERALD HARMON, M.D., M.P.H.**
Résumé – August 9, 1996

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## CURRENT POSITION

January 1996-present **National** Medical **Director, OPTUM** Division and Medical **Services** Group, **United HealthCare** Corp. Medical consultant for health and human risk management programs including telephone health advice, prevention publications, heafth risk appraisal, and health promotion services. Also responsible for medical policy development in areas of disease management, maternity management, and clinical preventive services

## PROFESSIONAL EXPERIENCE

October1994-December 1995 Senior Vice **President and** Medical Director, Center **for Corporate Health,** Inc., Oakton, VA. CCHI was a subsidiary of MetraHealth prior to its October, 1995 acquisition by United HealthCare Corp. and a leading company in the field of demand management or self care. The medical director was responsible for consultation win nursing staff, medical writing and editing, protocol development, quality improvement, and new product development.

January 1994-Sept. 1994: President and CEO, **The Harmon Health Group,** Potomac, MD. HHG is a health consulting firm specializing in health policy. managed care, public health, preventive medicine, and government relations.

July 1993-May 1994 Medical **Director, Employee Health** Programs **(EHP), Inc.,** Bethesda, MD. EHP is a leading company in the field of employee dng and health risk testing. Participated in medical review of test results and development of new products

Feb. 1990-May 1993: **Administrator** and CEO, **Health Resources** and Services **Administration (HRSA)**, USPHS, DHHS, Rockville, MD. Supervised an annual budget of $2.8 billion, more than 2,300 employees, and programs involving community and migrant health centers, the National Health Service Corps, maternal and child heafth, HIV/AIDS care, health professions training, organ transplantation, and the National Practitioner Data Bank. Published a strategic plan for the Year 2000, established and improved the National Practitioner Data Bank. reformed the National Vaccine Injury Compensation Program, implemented a TQM (total quality management) program with over 60 quality councils. reorganized the information systems office and created an agency-wide computer network, and upgraded the public information office while launching a nationwide media campaign for the Healthy start infant mortality initiative.

1986-1990 **Director, Missouri Department** of **Health**, Jefferson City, MO. Supervised an annual budget of $160 million, 1200 employees. and statewide public health programs. Developed a strategic plan for the Year 2000, established a Division of Chronic Disease Prevention and Health Promotion, consolidated computer systems into a single new office and network, initiated a successful merger of the Ellis Fischel State Cancer Center with the University of Missouri-Columbia, and helped enact and implement a comprehensive AIDS faw and program an4 state medical liability insurance coverage for indigent obstetric and pediatric care.

1980-1985 **Chairman, Department** of Community **Medicine, Maricopa Medical Center** (1980-85). Deputy **Director** of **Public Health** (1980-82), and **Director** of **Public Health and Health** Officer (1982-85), Maricopa County Dept. of Health Services, Phoenix, AZ. Supervised a public health agency with 750 employees and annual budget of $30 million, managed a network of 14 primary care centers, and served as chief physician for a primary care group practice of over 30 physicians and 20 nurse practitioners and physician assistants. Helped launch the Maricopa Health Plan, a group-model HMO under the Arizona Health Care Cost Containment System(AHCCCS), the nations's first statewide prepaid Medicaid program. Upgraded and ran the hospital ambulatory and urgent care center, established a successful ambulatory care quality improvement program, and founded Maricopa Community Medicine Associates, a large primary care group practice. Helped start a

homeless health center under a Robert Wood Johnson Foundation grant, upgraded correctional health services, founded the Arizona County Health Officials Association, and served as president of the National Association of County Health Officials.

1977-1 980: **Director, MEDEX Northwest Division, Department of Health Services, School of Public Health and Community Medicine, University of** Washington, Seattle, WA. Supervised a training program for primary care physician assistants serving the States of WA. OR, AK, MT, and ID: taught physician assistant, nurse practitioner, medical, and public health students; and conducted health services research. Won 8 number of training and research grants, expanded Alaska training opportunities, and started a successful community health worker program.

1974.1977: **Emergency medicine part-time staff physician.** Prince Georges General Hospital, Cheverly, MD

1974-1975: **Medical officer**, PSRO program, Buroau of Quality Assurance, USPHS, Dept. of HEW. Rockville, MD

## EDUCATION

1975-1977: **M.P.H.** (Master of Public Health), School of Hygiene and Public Health, Johns Hopkins University, Baltimore, MD

19661970: **M.D.**. *Washington* University School of Medicine, St. Louis. MO

1x2-1966: B.A. (zoology), Washington University, St Louis, MO

## POSTGRADUATE TRAINING

July 1988: **Program for Senior Executives in State and Local Government**, Harvard University, John F. Kennedy School of Government

1970-73: **Internship, residency – internal medicine**, Univ. of Colorado Medical Cntr., Denver, CO

## ACADEMIC APPOINTMENTS

1986-1990: **Clinical Professor, Dept.** of Family and Community Medicine, Univ. of Missouri at Columbia School of Medicine, Columbia, MO

1981-1985: Adjunct **Associate Professor**, Dept. of Family and Community Medicine. University of Arizona School of Medicine, Tucson, AZ

1977-1980: **Assistant Professor**, Dept. of Health Services, School of Public Health and Community Medicine; Adjunct Assistant Professor, Dept. of Medicine, School of Medicine; University of Washington, Seattle, WA

**CONSULTATIONS:** Available on request, including for Me Office of the Assistant Secretary for Health Robert Wood Johnson Foundation, Institute of Medicine, Pan American and World Health Organizations, U.S. Agency for International Development, and Project HOPE.

**MEDICAL LICENSURE & CERTIFICATION:** States of VA, AZ, WA, MD, CO, and MO, plus National Board of Medical Examiners. **Specialty** board **certification:** General Preventive Medicine, November 1979 (#40535). **Specialty board eligibility:** Internal Medicine, 1973

**PUBLICATIONS:** Over 40, available on request, dealing with clinical internal medicine, primary care policy and training, managed care. pubfii health administration, quality improvement, international health, HIV/AIDS, end epidemiology.

**PERSONAL DATA: Born March** 20, 1944, Barnsdall, OK; married, two children; Soc Sec #323-38-8554

***Partnership for Prevention***
**Federal Sources of Support**

| PROJECT TITLE | AGENCY | AWARD NUMBER | AMOUNT |
|---|---|---|---|
| A Forum on Self-Care and Demand Management | Agency for Health Care Policy and Research, DHHS | R13 HS09356-01 | $49,645 |
| immunizing America's Children, Adolescents and Adults: A Symposium on Blending Public Policy with Corporate Objectives | Centers **for' Disease** Control and Prevention, DHHS | R13/CCR 312610-01 | $40,000 |
| Developing a Benchmark Prevention Benefits Package | Centers for Disease Control and Prevention (through a subcontract with The HMO Group) | CDC Contract #200-95-0953, Task #0953-005 | $220,075 |
| The Role of Health Plans in Community-Level Health Improvement Activities | Office of Disease Prevention and Health Promotion, DHHS | Cooperative Agreement No. HPU 960001-01 | $466,907 |